

HIPAA 5010

Attention: Local Plan SD/MC Providers

STOP - Impact on You

The Department of Mental Health (DMH) is pleased to announce that the Integrated Systems (IS) complies with the new Health Insurance Portability and Accountability (HIPAA) 5010 transaction standard for submitting claims mandated by the Centers for Medicare and Medicaid Services. On March 29, 2012 DMH implemented modifications to the Integrated System (IS) for Direct Data Entry (DDE) claiming and on April 2, 2012 the implementation was extended to the Electronic Data Interchange (EDI) claiming to comply with the HIPAA 5010 standard. This bulletin illustrates how these changes affect the submission of claims in the IS.



CAUTION – What You Need to Know

Client Information – Contacts Tab

The Client Information screen has been modified to expand the ZIP code field from 5 digits to 9 digits, it is recommended to add the extension to ZIP code when ever possible. The first five digits of the ZIP code field are required. It is also very important to identify "Transient/Homeless" clients by selecting the box when the client is homeless.

Client Information- Contacts tab screen



Outpatient, & Day Treatment Service screens

The Outpatient and Day Treatment Service screens have been modified to include two new fields displayed as checkboxes labeled:

- o Patient Signature Not Available Field Not Required
- o Provider Signature on File Field Required

These new fields are defined by Department of Mental Health - Quality Assurance in the QA Bulletin dated March 23, 2012, No. 12-02. Based on the bulletin checking the Patient Signature Not Available box indicates that the client's signature was generated by the provider on behalf of the client. The bulletin also states, when checking the required Provider Signature on File box *confirms* that there is a signature on file verifying that the service is true and accurate. Images of the screens are included in this bulletin, see below.

Outpatient Service screen



Day Treatment Service screen



NOTE: The *Medicare Certified* checkbox was removed from both Outpatient & Day Treatment Service screens.



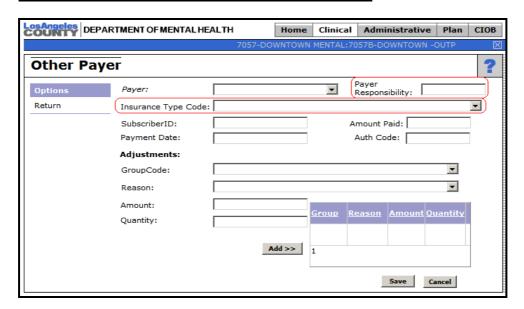
Outpatient & Day Treatment Other Payer screens

The Outpatient and Day Treatment Other Payer screens have been modified to include two new fields labeled:

- o Payer Responsibility Field required
- Insurance Type Code Field required when Medicare is the Secondary Payer for the claim.

The Payer Responsibility identifies the client's insurance carrier's level of responsibility for the claim entered as 1 for *Primary*, 2 for *Secondary*, 3 for *Tertiary*, and so forth depending on the number of payers the client may have. The Insurance Type Code needs to be reported on the claim when Medicare's level of responsibility is secondary (2), meaning that the client's Other Insurance is primary (1) for the claim.

Outpatient & Day Treatment Other Payer screen



Inpatient Episode Admission screen

The Inpatient Episode Admission screen has been modified to include a new required field labeled:

Point of Origin – Field Required

The Point of Origin code indicates where the client came from prior to presenting at the facility or who has recommended the client for admission.

Inpatient Episode Admission screen



• Inpatient Service screen

The Inpatient Service screen has been modified to include four new required fields labeled:

- Facility Type Code Field Required
- Type of Admission Field Required
- Patient Status Code Field Required
- o Provider Signature on File Field Required

Inpatient Service screen



The Facility Type Code identifies where services were rendered, this field used to be *Place of Service*. The Type of Admission identifies the priority of the admission or visit to the facility, this field used to be *Necessity* on the Admission tab of the Episode screen and has been moved to the Inpatient Service screen. The Patient Status Code identifies the disposition or discharge status of the patient, this field used to be on the Discharge tab of the Episode screen and has been moved to the Inpatient Service screen. The Provider Signature on File again as stated in QA Bulletin confirms that there is a signature on file for the provider verifying that the services are true and accurate.

Inpatient Other Payer screen

The Inpatient Other Payer screen has been modified to include one new required field labeled:

Payer Responsibility - Field Required

The Payer Responsibility identifies the client's insurance carrier's level of responsibility for the claim entered as 1 for *Primary*, 2 for *Secondary*, 3 for *Tertiary*, and so forth depending on the number of payers the client may have.

Inpatient Other Payer screen



GO - What You Need to Do

Visit the IS Website to review the HIPAA 5010 Training Presentation for an in depth explanation of all HIPAA 5010 edit messages or click on the link below.

http://lacdmh.lacounty.gov/hipaa/documents/5010ISScreenModifications 030112.pdf

Review the DMH-QA Bulletin No. 12-02 for questions on the following new fields:

- o Patient Signature Not Available
- o Provider Signature on File
- Facility Type CodeType of Admission
- o Patient Status Code

http://file.lacounty.gov/dmh/cms1_176106.pdf

Review the updated reference material:

• EDI Deny Reason Cheat Sheet – click on link

http://lacdmh.lacounty.gov/hipaa/documents/DenyRuleCheatSheet_5010.pdf

If you have any questions regarding new edits and/or business rules in the IS, please contact the Help Desk at (213) 351-1335.

If you have billing questions, please contact the Revenue Management Division by phone at (213) 480-3444 or by email at RevenueManagement@dmh.lacounty.gov.